

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001116	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/15/2015
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NAME OF PROVIDER OR SUPPLIER  CLI SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 W LINCOLN RD KOKOMO, IN 46904
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Q 0000  Bldg. 00	This visit was for a re-certification survey.  Facility Number: 002845  Survey Date: 4/13/2015 through 4/15/2015  QA: cjl 05/06/15	Q 0000		
Q 0101  Bldg. 00	416.44(a)(1) PHYSICAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. Based on documentation review, observation, and staff interview, the facility failed to maintain the temperature of the two operating rooms between 68 and 73 degrees Fahrenheit as defined by the center's policy.	Q 0101	The balance between the thermostat and humidistat is adjusted by the DON to achieve the acceptable temperature humidity and temperature ranges. A new system will be installed by July 15th. In the interim, the DON will continue to check daily and monitor the temperature to ensure guidelines are met.	04/15/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Temperature and humidity monitoring policy (last revised 10/17/2014) indicated acceptable temperature ranges for the operating rooms shall be between 68 and 73 degrees Fahrenheit. The policy references AORN (Association of periOperative Registered Nurses) guidelines which are the same acceptable range.</li> <li>2. CLI Surgery Center Temperature/Humidity log for Operating Room #B was reviewed for the period between 12/31/14 and 4/15/15. The temperature was recorded 27 days. Eight (12/31/14, 1/6-7/15, 1/13-14/15, 1/27-28/15, 2/10/15) of the 27 days, the temperature was recorded less than 67 degrees Fahrenheit.</li> <li>3. CLI Surgery Center Temperature/Humidity log for Operating Room #A was reviewed for the period between 2/10/14 and</li> </ol>			
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Q 0181 Bldg. 00	<p>4/15/15. The temperature was recorded 18 days. Two (3/11/15 &amp; 4/15/15) of the 18 days, the temperature was recorded less than 67 degrees Fahrenheit.</p> <p>4. At 10:45 AM on 4/15/2015, Operating Room #A thermostat noted the room was 66 degrees Fahrenheit. This was 2 degrees less than the acceptable range per center's policy and AORN guidelines.</p> <p>5. At 2:10 PM on 4/14, staff member #1 (Director of Nursing) confirmed the temperature ranges of the two operating rooms have been a continual issue for the surgery center.</p> <p>416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and</p>			

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	<p>acceptable standards of practice.</p> <p>Based on policy review, observation, and interview, the facility failed to ensure all medications were secured in locked cabinets to prevent unauthorized access.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility policy titled "Medication Control and Accountability", last reviewed 01/23/15, indicated, "5. All medication cabinets shall be locked and accessible only to authorized persons."</li> <li>During the tour of the Surgical Sterile Core area at 11:40 AM on 04/15/15, accompanied by staff member #7, an LPN (Licensed Practical Nurse), a drawer and cabinet containing a large quantity of injectable medications, Lidocaine, Epinephrine, Marcaine, Sodium Bicarbonate, Solu-Cortef, and Vancomycin, were observed without any locking devices. The room also was not locked.</li> <li>At 11:40 AM on 04/15/15, staff member #7 indicated the staff from the contracted cleaning service would clean in that room unattended in the evenings and acknowledged the drawer did not lock to secure the medications.</li> </ol>	O 0181	<b>Acabinet that locks was installed in the sterile core area for storage of these medications.</b>	05/14/2015			

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Q 0241  Bldg. 00	<p>416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on policy review, contracted cleaning personnel file review, document review, and interview, the facility failed to ensure environmental services were provided to ensure the safety and well-being of the patients treated in the facility.</p> <p>Findings included:</p> <p>1. The facility policy "Infection Control Plan", last reviewed 01/23/15, indicated, "The Infection Control Officer will be responsible for the ongoing infection control activities and will provide information to the QA&amp;I (Quality Assurance &amp; Improvement) Committee for incorporation in their review. ...Personnel: ...3. All new employees shall be inserviced on infection control polices and follow Center policies."</p> <p>2. The contracted cleaning company's binder indicated a New Hire Orientation Checklist for staff member #10, the housekeeper for the Center, from 09/10/13 which indicated training had been provided on Personal Protective</p>	O 0241	<p>#1 ·All new employees will be in-serviced annually on infection control policies by the infection control officer. The DON will be responsible for ensuring compliance.</p> <p>#2 ·With all new housekeeping staff, DON will review the policy and procedure manual and make staff member aware of where the manual is located and kept.</p> <p>#3 ·Infection control officer will bedoing quarterly observations and evaluation of the cleaning staff. Check list is already in place and has been done by the DON.</p> <p>#4 ·DON spoke with cleaning staff andinfection control nurse and instructedon proper mixture of cleaning chemicals which is 2 ounces of cleaning chemicalper 1 gallon of water per the cleaning chemical manufacturer. ·DON has instructed cleaning staff and manager of cleaning company that after the D-Cide spray is applied tosurfaces it</p>	05/12/2015			

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	<p>Equipment, Universal Precautions Training, Vaccination Policy, Chemicals Usage and Storage, Blood Borne Pathogens Training, Terminal and Environmental Cleaning Process and Procedures, and MSDS Book Usage and Location. The checklist also indicated the housekeeper initialed the Center Acknowledgement of Policies &amp; Procedures Form. The checklist was signed by staff member #10 and the cleaning company manager. The binder also contained an acknowledgement from 09/10/14, signed by staff member #10, which indicated, "I hereby acknowledge that the Policy and Procedure Manual for the [facility] has been provided to me with a section labeled Infection Control. I also hereby acknowledge that I have been made aware of the location of this manual in its entirety. I have reviewed the contents and I will adhere to the standards of practice made accessible defined therein."</p> <p>3. At 11:50 AM on 04/14/15, the Infection Control Nurse, staff member #3, was interviewed. He/she indicated he/she had not provided any direct training to the housekeeper, but the staff member read the policies &amp; procedures annually. He/she also indicated he/she did not observe the housekeeper while he/she was cleaning the facility. He/she</p>		<p><b>must remain on the surface for 3 minutes before wiping off. The DON will designate The Infection control officer to perform quarterly observation of the cleaning crew #5</b></p> <p><b>·DON has instructed cleaning staff and informed cleaning manager of proper mixture of cleaning chemicals.</b></p>				

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	<p>indicated he/she thought the DON (Director of Nursing), staff member #1, did quarterly observations and the housekeeper completed nightly tasks checklists. He/she indicated he/she was not sure about mixing the chemicals for cleaning.</p> <p>4. At 1:30 PM on 04/14/15, the housekeeper, staff member #10, came in early to be interviewed. He/she indicated he/she had worked at the facility for a year and seven months. He/she indicated his/her training consisted of reading information provided by the contracted company and on-the job training by the manager. He/she indicated he/she had not received any training from the Center and denied reading any information from the policy and procedure manual. He/she indicated the DON had observed an OR (Operating Room) cleaning once and indicated the company staff had not done any observations since his/her initial training. He/she indicated he/she used D-Cide 2 spray for cleaning surfaces and sprayed it on and immediately wiped it off. The label directions indicated the chemical was to remain on the surfaces for three minutes to kill the organisms. Staff member #10 indicated he/she used the chemical Shine-On NDC (Neutral Disinfectant Cleaner) for the floors and walls of the OR and mixed 4 pumps to 4-</p>			

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Q 0242  Bldg. 00	<p>5 gallons of water in the mop bucket and 3 pumps to 3 and 1/2 gallons of water for the walls. The dispenser pump had markings of 1/4, 1/2, and 2/3 ounce and staff member #10 indicated he/she thought a full pump was one ounce. The label directions indicated for effective disinfection two ounces of chemical should be mixed with each gallon of water.</p> <p>5. At 10:00 AM on 04/15/15, the chemicals and markings on the pump were discussed with staff member #1 who also indicated it appeared one pump was one ounce so the chemicals weren't mixed according to label directions. He/she indicated he/she had just recently started observations of the housekeeper, but had not observed the actual chemical mixing or timing.</p> <p>416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. Based on policy review, review of</p>	O 0242	For all new hires, if they do not	05/11/2015			

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	<p>product information, employee files review, and interview, the facility failed to ensure TB testing was performed per policy, manufacturer's recommendations and CDC guidelines for four of nine staff member files reviewed (P2, P4, P5, P5, and P8) and for one of one contracted cleaning staff member (#10).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility policy "Physical Examination, Tuberculosis Screening and Verification Immunity)", last reviewed 01/23/15, indicated, "The Center provides skin testing for tuberculosis for all employees, volunteers, and contracted employees. ...2. All employees and volunteers shall receive TB (PPD) screening according to the Centers for Disease Control and Prevention (CDC)." CDC guidelines specified tests to be read between 48 and 72 hours and recommended two-step TB testing for all new employees unless a documented negative test within the last year could be provided.</li> <li>The manufacturer's product information for Tubersol, the solution used for TB testing, indicated the tests should be placed and read within 48 to 72 hours for accuracy.</li> </ol>				<p><b>have record of a current (within last 12 months)TB, we will proceed with a 2-step TB test. If new employee has a current record of a TB test, we will ask fordocumentation and obtain record for employee file and then we will proceed withsecond step TB skin test one month after the initial TB test was performed.Once we read the test it will be documented with date and time on both readings and kept in employee file. The DON will be responsible for ensuring compliance</b></p>		

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	<p>3. The health file for staff member P2, an LPN (Licensed Practical Nurse) with a hire date of 06/25/14, indicated the first-step TB test was placed on 09/10/14, but the record lacked documentation of a second test.</p> <p>4. The health file for staff member P4, an RN (Registered Nurse) with a hire date of 02/20/08, indicated an annual TB test placed on 01/28/15 at 1400 hours and read on 01/30/15, but with no time documented to determine the reading was between 48 and 72 hours later.</p> <p>5. The health file for staff member P5, an RN with a hire date of 01/25/11, indicated an annual TB test placed on 01/28/15 at 1405 hours and read on 01/30/15, but with no time documented to determine the reading was between 48 and 72 hours later.</p> <p>6. The health file for staff member P8, a Surgical Tech with a hire date of 05/20/14, indicated the first-step TB test was placed on 06/11/14, but the record lacked documentation of a second test.</p> <p>7. The contracted cleaning company binder indicated documentation for the housekeeper for the facility, staff member #10 with a hire date of 09/10/13, but lacked documentation of any TB testing.</p>			

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S 0000  Bldg. 00	<p>A document in the file indicated the company did not require any vaccinations, including tuberculosis, for any of its employees.</p> <p>8. At 1:30 PM on 04/14/15, the contracted housekeeper, staff member #10, confirmed he/she had not received any TB testing by the cleaning company or the Center.</p> <p>9. At 9:30 AM on 04/15/15, staff member #1, the Director of Nursing, confirmed the findings with the TB testing. He/she indicated staff member P2 indicated he/she had TB testing with the military, but had difficulty obtaining the results which was why a single TB test was placed a couple of months after hire. He/she indicated the lack of time documentation for staff members P4 and P5 was just an oversight on his/her part. He/she confirmed no TB testing was performed on the contracted housekeeper.</p> <p>This visit was for a State licensure survey.</p>	S 0000		

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S 0230  Bldg. 00	<p>Facility Number: 002845</p> <p>Survey Date: 4/13/2015 through 4/15/2015</p> <p>QA: cjl 05/06/15</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on documentation review and staff interview, the facility failed to provide for a periodic review of the center and its operation by three or more licensed</p>	S 0230	<b>To credential a third physician that doesn't have financial interest. The DON will be responsible for ensuring compliance</b>	05/13/2015	

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S 0400 Bldg. 00	<p>physicians which have no financial interest in the facility.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. The Medical Record/Peer Review/Utilization Review Worksheets for 2014 were reviewed. The review worksheets were conducted only by two physicians that are credentialed by the medical staff; however, do not have financial interest in the facility.</li> <li>2. At 12:05 PM on 4/13/2015, staff member #1 (Director of Nursing) confirmed the center only has two physicians on the peer review committee.</li> </ol> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p>						

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	<p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to maintain the temperature of the two operating rooms between 68 and 73 degrees Fahrenheit as defined center's policy.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Temperature and humidity monitoring policy (last revised 10/17/2014) indicated acceptable temperature ranges for the operating rooms shall be between 68 and 73 degrees Fahrenheit. The policy references AORN (Association of periOperative Registered Nurses) guidelines which are the same acceptable range.</li> <li>2. CLI Surgery Center Temperature/Humidity log for Operating Room #B was reviewed</li> </ol>	S 0400	<p>The balance between the thermostat and humidistat is adjusted by the DON to achieve the acceptable temperature humidity and temperature ranges. A new system will be installed by July 15th. In the interim, the DON will continue to check daily and monitor the temperature to ensure guidelines are met.</p>	04/15/2015

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	<p>for the period between 12/31/14 and 4/15/15. The temperature was recorded 27 days. Eight (12/31/14, 1/6-7/15, 1/13-14/15, 1/27-28/15, 2/10/15) of the 27 days, the temperature was recorded less than 67 degrees Fahrenheit.</p> <p>3. CLI Surgery Center Temperature/Humidity log for Operating Room #A was reviewed for the period between 2/10/14 and 4/15/15. The temperature was recorded 18 days. Two (3/11/15 &amp; 4/15/15) of the 18 days, the temperature was recorded less than 67 degrees Fahrenheit.</p> <p>4. At 10:45 AM on 4/15/2015, Operating Room #A thermostat noted the room was 66 degrees Fahrenheit. This was 2 degrees less than the acceptable range per center's policy and AORN guidelines.</p> <p>5. At 2:10 PM on 4/14, staff member #1 (Director of Nursing) confirmed the temperature ranges</p>			

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S 0422 Bldg. 00	<p>of the two operating rooms have been a continual issue for the surgery center.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk.</p> <p>Based on review of product information, employee files review, policy review, and interview, the facility failed to ensure TB testing was performed per policy, manufacturer's recommendations and CDC guidelines for four of nine staff member files reviewed (P2, P4, P5, P5, and P8) and for one of one contracted cleaning staff member (#10).</p> <p>Findings included:</p> <p>1. The facility policy "Physical Examination, Tuberculosis Screening and Verification Immunity", last reviewed 01/23/15, indicated, "The Center provides skin testing for tuberculosis for</p>	S 0422	<p>For all new hires, if they do not have record of a current (within last 12 months) TB, we will proceed with a 2-step TB test. If new employee has a current record of a TB test, we will ask for documentation and obtain record for employee file and then we will proceed with second step TB skin test one month after the initial TB test was performed. Once we read the test it will be documented with date and time on both readings and kept in employee file. The DON will be responsible for ensuring compliance</p>	05/11/2015

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	<p>all employees, volunteers, and contracted employees. ...2. All employees and volunteers shall receive TB (PPD) screening according to the Centers for Disease Control and Prevention (CDC)." CDC guidelines specified tests to be read between 48 and 72 hours and recommended two-step TB testing for all new employees unless a documented negative test within the last year could be provided.</p> <p>2. The manufacturer's product information for Tubersol, the solution used for TB testing, indicated the tests should be placed and read within 48 to 72 hours for accuracy.</p> <p>3. The health file for staff member P2, an LPN (Licensed Practical Nurse) with a hire date of 06/25/14, indicated the first-step TB test was placed on 09/10/14, but the record lacked documentation of a second test.</p> <p>4. The health file for staff member P4, an RN (Registered Nurse) with a hire date of 02/20/08, indicated an annual TB test placed on 01/28/15 at 1400 hours and read on 01/30/15, but with no time documented to determine the reading was between 48 and 72 hours later.</p> <p>5. The health file for staff member P5,</p>						

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	<p>an RN with a hire date of 01/25/11, indicated an annual TB test placed on 01/28/15 at 1405 hours and read on 01/30/15, but with no time documented to determine the reading was between 48 and 72 hours later.</p> <p>6. The health file for staff member P8, a Surgical Tech with a hire date of 05/20/14, indicated the first-step TB test was placed on 06/11/14, but the record lacked documentation of a second test.</p> <p>7. The contracted cleaning company binder indicated documentation for the housekeeper for the facility, staff member #10 with a hire date of 09/10/13, but lacked documentation of any TB testing. A document in the file indicated the company did not require any vaccinations, including tuberculosis, for any of its employees.</p> <p>8. At 1:30 PM on 04/14/15, the contracted housekeeper, staff member #10, confirmed he/she had not received any TB testing by the cleaning company or the Center.</p> <p>9. At 9:30 AM on 04/15/15, staff member #1, the Director of Nursing, confirmed the findings with the TB testing. He/she indicated staff member P2 indicated he/she had TB testing with</p>			

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S 0444 Bldg. 00	<p>the military, but had difficulty obtaining the results which was why a single TB test was placed a couple of months after hire. He/she indicated the lack of time documentation for staff members P4 and P5 was just an oversight on his/her part. He/she confirmed no TB testing was performed on the contracted housekeeper.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on policy review, observation, and interview, the facility failed to ensure the surgical staff followed their dress code policy regarding surgical masks.</p> <p>Findings included:</p> <p>1. The facility policy "Surgical Attire",</p>	S 0444	<p><b>·All nursing staff, Doctor's and CRNA's has been educated on the policy for proper surgical attire per AORN guidelines. The DON will do weekly audits on ensuring all surgical staff are following proper surgical attire This will be included in our Quality</b></p>	05/12/2015

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	<p>last reviewed 01/23/15, indicated, "Masks are either on or off. It is not acceptable for masks to be hanging from the neck."</p> <p>2. While observing in the pre/post area, beginning at 9:40 AM on 04/15/15, a female staff member was observed walking to the waiting area desk to get information, with a surgical mask covering her nose and mouth. Two other female staff members came out of the surgical area, one wearing the mask and the other with the mask hanging around her neck, then returned to the OR (Operating Room). At 10:20 AM, a female staff member came out of the OR, put her mask in her pocket, asked some questions of the DON, Director of Nursing, then pulled the mask out of her pocket, put it back on, and returned to the OR to set up for the next procedure. At 11:45 AM, staff member #6, a CRNA (Certified Registered Nurse Anesthetist), came from the OR into the post-op area with a mask around his/her neck.</p> <p>3. At 12:45 PM on 04/15/15, staff member #1, the Director of Nursing, confirmed the facility followed AORN (Association of periOperative Registered Nurses) recommendations which indicated surgical masks were to be changed between cases and not worn</p>		<b>Assurance Program The DON will be responsible for ensuring compliance</b>		

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S 1026  Bldg. 00	<p>around the neck or stored in pockets.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)(i)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>(i) Drug cabinets must be accessible only to authorized personnel.</p> <p>Based on policy review, observation, and interview, the facility failed to ensure all medications were secured in locked cabinets to prevent unauthorized access.</p> <p>Findings included:</p> <p>1. The facility policy titled "Medication Control and Accountability", last reviewed 01/23/15, indicated, "5. All medication cabinets shall be locked and accessible only to authorized persons."</p> <p>2. During the tour of the Surgical Sterile</p>	S 1026	<b>Acabinet that locks was installed in the sterile core area for storage of these medications.</b>	05/14/2015			

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S 1174 Bldg. 00	<p>Core area at 11:40 AM on 04/15/15, accompanied by staff member #7, an LPN (Licensed Practical Nurse), a drawer and cabinet containing a large quantity of injectable medications, Lidocaine, Epinephrine, Marcaine, Sodium Bicarbonate, Solu-Cortef, and Vancomycin, were observed without any locking devices. The room also was not locked.</p> <p>3. At 11:40 AM on 04/15/15, staff member #7 indicated the staff from the contracted cleaning service would clean in that room unattended in the evenings and acknowledged the drawer did not lock to secure the medications.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(A)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept</p>						

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	<p>clean and orderly in accordance with current standards of practice, including the following:</p> <p>(A) Environmental services must be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(i) Asepsis. (ii) Cross-contamination prevention. (iii) Safe practice.</p> <p>Based on policy review, contracted cleaning personnel file review, document review, and interview, the infection control committee failed to ensure environmental services were provided to ensure the safety and well-being of the patients treated in the facility.</p> <p>Findings included:</p> <p>1. The facility policy "Infection Control Plan", last reviewed 01/23/15, indicated, "The Infection Control Officer will be responsible for the ongoing infection control activities and will provide information to the QA&amp;I (Quality Assurance &amp; Improvement) Committee for incorporation in their review. ...Personnel: ...3. All new employees shall be inserviced on infection control polices and follow Center policies."</p> <p>2. The contracted cleaning company's</p>	S 1174	<p>#1 -All new employees will bein-serviced annually on infection control policies by the infection control officer The DON will be responsible for ensuring compliance.</p> <p>#2 -With all new housekeeping staff,DON will review the policy and procedure manual and make staff member aware ofwhere the manual is located and kept.</p> <p>#3 -Infection control officer will bedoing quarterly observations and evaluation of the cleaning staff. Check list is already in place and has beendone by the DON.</p> <p>#4 -DON spoke with cleaning staff andinfection control nurse and instructedon proper mixture of cleaning chemicals which is 2 ounces of cleaning</p>	05/12/2015

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	<p>binder indicated a New Hire Orientation Checklist for staff member #10, the housekeeper for the Center, from 09/10/13 which indicated training had been provided on Personal Protective Equipment, Universal Precautions Training, Vaccination Policy, Chemicals Usage and Storage, Blood Borne Pathogens Training, Terminal and Environmental Cleaning Process and Procedures, and MSDS Book Usage and Location. The checklist also indicated the housekeeper initialed the Center Acknowledgement of Policies &amp; Procedures Form. The checklist was signed by staff member #10 and the cleaning company manager. The binder also contained an acknowledgement from 09/10/14, signed by staff member #10, which indicated, "I hereby acknowledge that the Policy and Procedure Manual for the [facility] has been provided to me with a section labeled Infection Control. I also hereby acknowledge that I have been made aware of the location of this manual in its entirety. I have reviewed the contents and I will adhere to the standards of practice made accessible defined therein."</p> <p>3. At 11:50 AM on 04/14/15, the Infection Control Nurse, staff member #3, was interviewed. He/she indicated he/she had not provided any direct</p>		<p><b>chemical per 1 gallon of water per the cleaning chemical manufacturer.</b></p> <p><b>-DON has instructed cleaning staff and manager of cleaning company that after the D-Cide spray is applied to surfaces it must remain on the surface for 3 minutes before wiping off.</b></p> <p><b>#5</b></p> <p><b>-DON has instructed cleaning staff and informed cleaning manager of proper mixture of cleaning chemicals.</b></p>				

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	<p>training to the housekeeper, but the staff member read the policies &amp; procedures annually. He/she also indicated he/she did not observe the housekeeper while he/she was cleaning the facility. He/she indicated he/she thought the DON (Director of Nursing), staff member #1, did quarterly observations and the housekeeper completed nightly tasks checklists. He/she indicated he/she was not sure about mixing the chemicals for cleaning.</p> <p>4. At 1:30 PM on 04/14/15, the housekeeper, staff member #10, came in early to be interviewed. He/she indicated he/she had worked at the facility for a year and seven months. He/she indicated his/her training consisted of reading information provided by the contracted company and on-the job training by the manager. He/she indicated he/she had not received any training from the Center and denied reading any information from the policy and procedure manual. He/she indicated the DON had observed an OR (Operating Room) cleaning once and indicated the company staff had not done any observations since his/her initial training. He/she indicated he/she used D-Cide 2 spray for cleaning surfaces and sprayed it on and immediately wiped it off. The label directions indicated the chemical was to remain on the surfaces</p>			

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	<p>for three minutes to kill the organisms. Staff member #10 indicated he/she used the chemical Shine-On NDC (Neutral Disinfectant Cleaner) for the floors and walls of the OR and mixed 4 pumps to 4-5 gallons of water in the mop bucket and 3 pumps to 3 and 1/2 gallons of water for the walls. The dispenser pump had markings of 1/4, 1/2, and 2/3 ounce and staff member #10 indicated he/she thought a full pump was one ounce. The label directions indicated for effective disinfection two ounces of chemical should be mixed with each gallon of water.</p> <p>5. At 10:00 AM on 04/15/15, the chemicals and markings on the pump were discussed with staff member #1 who also indicated it appeared one pump was one ounce so the chemicals weren't mixed according to label directions. He/she indicated he/she had just recently started observations of the housekeeper, but had not observed the actual chemical mixing or timing.</p>			